

PRINTED: 09/22/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/13/2017
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N 000	Initial Comments A Licensure survey was completed at Brookhaven Manor Nursing Home on 9/11/17 - 9/13/17. No health deficiencies were cited under Chapter 1200-8-5, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:

STATE FORM

UO2111

If continuation sheet 1 of 1